

**4/10/2020**

**Updated COVID-19**

**Packaging & Shipping Using**

**Kit 51-For Local Health**

**Departments**

Prevent Disease – Promote Wellness – Improve Quality of Life



# COVID-19 Kit 51 Components

- After kit receipt
  - Take ice pack out and place in freezer
  - Viral transport media can be stored at room temp. or refrigerated

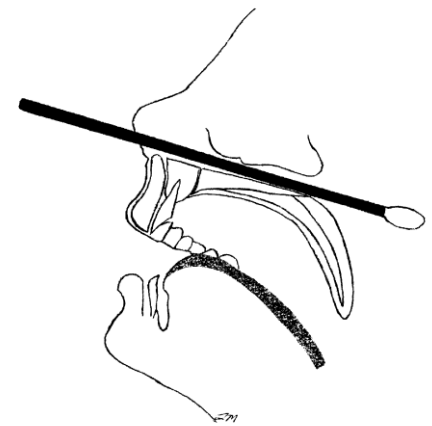
**Note:** It's acceptable to keep kit at room temp except ice pack (freezer) until used
- Additional Information
  - It is preferable to collect NP specimens.
  - **Note:** Although there are other acceptable specimen types for testing, only one specimen per patient will be tested, unless prior approval is obtained.



# Nasopharyngeal Collection Instructions

- Use only synthetic fiber swabs with plastic shafts.
  - Do not use calcium alginate or wooden shaft swabs that may inhibit PCR testing.
- *Nasopharyngeal (NP) swab*: Insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions
- After collection, place swab immediately into viral transport media (i.e. VTM, M4).

NP Collection





# Additional Acceptable Collection Swabs

- Oropharyngeal (OP) specimen collected by a healthcare professional
- Nasal mid-turbinate (NMT) swab collected by a healthcare professional or by onsite self-collection (using a flocked tapered swab)
- Anterior nares (nasal swab; NS) specimen collected by a healthcare professional or by onsite self-collection (using a flocked or spun polyester swab).
  - **Note:** At this time anterior nares and mid-turbinate specimen collection are only appropriate for symptomatic patients and both nares should be swabbed.

# Packaging VTM Specimens

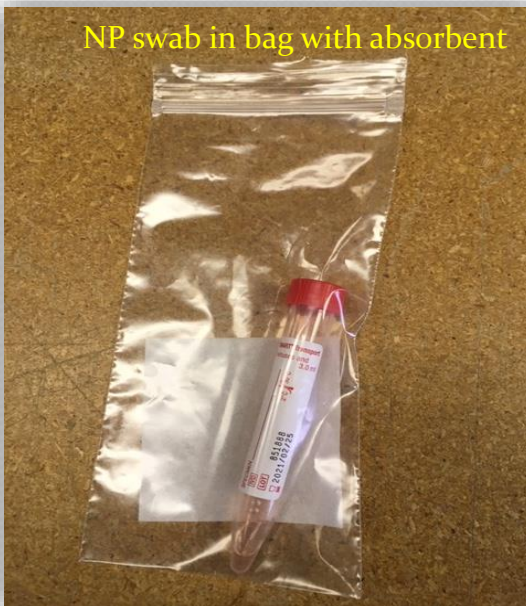
- Acceptable Specimens

- NP Swabs, OP swab, Nasal mid-turbinate (NMT) swab, anterior nares (nasal swab-both nares swabbed with a single swab)

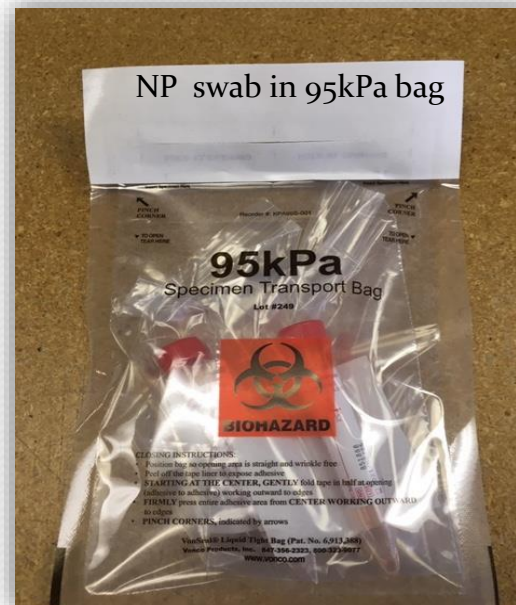
- Packaging

- Label tube with: Patient name, Date of Birth, & Source i.e. NP
- Place VTM tube (tighten cap) in plastic bag with absorbent material square
- Place sample in 95kPa bag

NP swab in bag with absorbent



NP swab in 95kPa bag

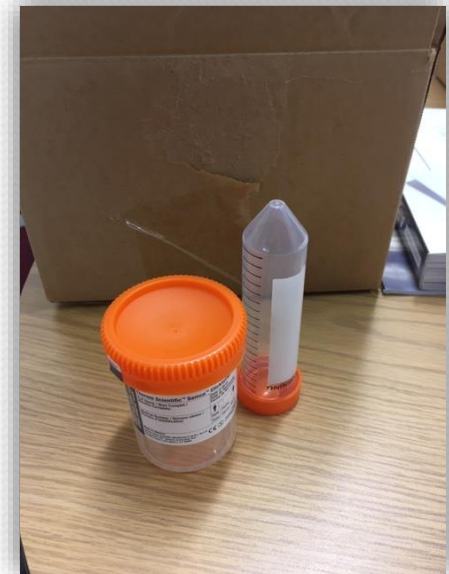




# Sputum Collection

- Have the patient rinse the mouth with water
- Next have patient expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
  - Note: Sub-optimal samples will be rejected (if not from deep cough collection)
- Sputum (sputum can be collected in a variety of sterile containers
  - Sterile urine cup or 50ml conical tube
  - Note: Collection containers not provided in kit.

Sterile cup & conical tube



# Packaging Sputum Specimens

- Acceptable Specimens
  - Sputum
- Packaging
  - Label container with:
    - Patient name, Date of Birth, & Source i.e. Sputum
  - Place sputum container inside the 95kPa bag with absorbent material square & VTM tube.

Sputum & NP swabs in separate bags with absorbent inside 95kPa bag





# Bronchoalveolar Lavage or Tracheal Aspirate

- Collect 2-3 mL of sample into a sterile, leak-proof, screw-cap sterile collection cup or sterile dry container.
- Package the same way as you would a sputum sample





- Complete State of Michigan Test Req Form DCH-0583

- Select “Other” in the “Tests that require MDHHS approval” section of the form and write in COVID-19

- Include case ID number, if available from completed MDHHS PUI form

STATE OF MICHIGAN - LABORATORY TEST REQUISITION			
Microbiology / Virology			
Michigan Department of Health and Human Services - Bureau of Laboratories P.O. Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing, MI 48909 Laboratory Records: 517-335-8059 Technical Information: 517-335-8067 Fax: 517-335-9871 Web: www.michigan.gov/mdhhs			
SUBMITTER INFORMATION			
NAME (LAST, FIRST, MIDDLE INITIAL) or ORGANIZATION _____ CONTACT PERSON/COORDINATING PHYSICIAN/PROVIDER NAME _____		AGENCY CODE (if known) <input type="checkbox"/> FP <input type="checkbox"/> STD TELEPHONE FAX NATIONAL PROVIDER IDENTIFIER #	
PATIENT INFORMATION			
NAME (LAST, FIRST, MIDDLE INITIAL) or UNIQUE IDENTIFIER _____ IDENTIFIER CATEGORY # (if Applicable) _____ CITY _____ ZIP _____ GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE RACE <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown ADAP NUMBER _____ BIRTH DATE (MM/DD/YYYY) _____ SUBMITTER SPECIES # _____ COLLECTION DATE (MM/DD/YYYY) _____ COLLECTION TIME (MILITARY) _____			
INDICATE TEST REQUESTED			
INSTRUCTIONS FOR COMPLETION: Complete reverse side of form for corresponding numbers in parentheses and in bold.			
INDICATE SPECIMEN SOURCE	SEROLOGY	MICROBIOLOGY	TESTS THAT REQUIRE MDHHS APPROVAL
<input type="checkbox"/> AMNIOTIC FLUID <input type="checkbox"/> BRONCHIAL <input type="checkbox"/> CERVICAL <input type="checkbox"/> CSF <input type="checkbox"/> GASTRIC <input type="checkbox"/> NASOPHARYNGEAL <input type="checkbox"/> ORAL MUCCAL TRANSUDATE <input type="checkbox"/> PLASMA <input type="checkbox"/> SERUM <input type="checkbox"/> STOOL <input type="checkbox"/> SPUTUM <input type="checkbox"/> THROAT <input type="checkbox"/> URETHRA <input type="checkbox"/> URINE <input type="checkbox"/> WHOLE BLOOD <input type="checkbox"/> FOOD-specify: <input type="checkbox"/> OTHER-specify:	SERUM STATUS - if Applicable <input type="checkbox"/> ACUTE <input type="checkbox"/> CONVALESCENT <input type="checkbox"/> ARBOVIRUS ENCOMP PANEL (lgM) May-Occ Includes: Eastern Equine, California, St. Louis and West Nile CSF Only <input type="checkbox"/> BRUCELLA SEROLOGY <input type="checkbox"/> FUNGAL SEROLOGY COMPLEMENT FIX <input type="checkbox"/> FUNGAL IMMUNODIFFUSION <input type="checkbox"/> FRANCISELLA SEROLOGY <input type="checkbox"/> LEGIONELLA - HA <input type="checkbox"/> LYME DISEASE - IFA (4) <input type="checkbox"/> MEASLES IgG <input type="checkbox"/> MUMPS IgG <input type="checkbox"/> RABIES AB SEROLOGY (3) <input type="checkbox"/> RUBELLA IgG <input type="checkbox"/> TETANUS TOXIN FR <input type="checkbox"/> VARICELLA ZOSTER IgG	<input type="checkbox"/> ARBOVIC ISOLATE ID (3) <input type="checkbox"/> ANTIMICROBIAL RESISTANCE CONF. (3) <input type="checkbox"/> AFB BLOOD CULTURE-CLINICAL SPECIMEN <input type="checkbox"/> AFB IDENTIFICATION-ISOLATE ID <input type="checkbox"/> ENTERIC BACTERIAL CULTURE <input type="checkbox"/> FOODBORNE ILLNESS-Isol or Food (3) <input type="checkbox"/> FUNGAL IDENTIFICATION - ISOLATE ID <input type="checkbox"/> LEGIONELLA CULTURE <input type="checkbox"/> NEISSERIA GONORRHOEA - ISOLATION <input type="checkbox"/> NEISSERIA - REFERRED CULTURE <input type="checkbox"/> PARASITOLOGY - BLOOD <input type="checkbox"/> PARASITOLOGY - STOOL <input type="checkbox"/> PARASITOLOGY - WORM <input type="checkbox"/> PERTUSSIS PCR <input type="checkbox"/> SALMONELLA SEROTYPING - HUMAN <input type="checkbox"/> SHIGELLA SEROTYPING <input type="checkbox"/> E. COLI SHIGA-TOXIN PRODUCER (STEC)	EMERGING ARBOVIRUS PANEL <input type="checkbox"/> PCR <input type="checkbox"/> SEROLOGY <input type="checkbox"/> AFB NUCLEIC ACID AMPLIFICATION <input type="checkbox"/> BACTERIAL TYPING-PFGE (3) <input type="checkbox"/> BOTULISM TOXIN <input type="checkbox"/> MUMPS - PCR <input type="checkbox"/> MEASLES IgM <input type="checkbox"/> NOROVIRUS PCR (3) <input type="checkbox"/> PERTUSSIS CULTURE <input type="checkbox"/> RUBELLA IgM (1) <input type="checkbox"/> SALMONELLA SEROTYPING NON-HUMAN <input type="checkbox"/> TOXIC SHOCK TESTING <input checked="" type="checkbox"/> OTHER COVID-19
HIV TESTING	SYPHILIS TESTING	VIROLOGY	OTHER
<input type="checkbox"/> HIV Ag/Ab - Serum (1) <input type="checkbox"/> HIV Ag/Ab-Oral Mucosal Transudate (1) <input type="checkbox"/> CD4/C8 (SDTA whole blood) (1) <input type="checkbox"/> HIV-1 VIRAL LOAD (SDTA plasma) (1) <input type="checkbox"/> HIV-1 GENOTYPING (SDTA plasma) (1)	<input type="checkbox"/> SYPHILIS PANEL (1) <input type="checkbox"/> SYPHILIS TP-FA (ONLY) (1) <input type="checkbox"/> SYPHILIS VDRL - CSF Only (1) <input type="checkbox"/> SYPHILIS DFA (1,2) <input type="checkbox"/> SYPHILIS IgM WESTERN BLOT (1)	<input type="checkbox"/> ENTEROVIRUS PCR (3) <input type="checkbox"/> RESPIRATORY PCR PANEL <input type="checkbox"/> INFLUENZA (PCR/CULTURE) (3) PATIENT STATUS (Influenza) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> VIRAL CULTURE	<input type="checkbox"/> AUTOCLAVE TEST STRIPS <input type="checkbox"/> LEGIONELLA - DFA <input type="checkbox"/> LYME DISEASE - DFA (Tox) HEPATITIS TESTING <input type="checkbox"/> HEPATITIS C ANTIBODY (1) <input type="checkbox"/> HEPATITIS B SURFACE ANTIGEN (HBsAg) (1) <input type="checkbox"/> HEPATITIS B ANTIBODY (Anti-HBc) (1) <input type="checkbox"/> HEPATITIS A ANTIBODY (IgM) (1)

DATE RECEIVED IN LABORATORY										LABORATORY SAMPLE NUMBER									
<p>Michigan Department of Health and Human Services - Bureau of Laboratories  P.O. Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing, MI 48909  Laboratory Records: 517-335-8059 Technical Information: 517-335-8067  Fax: 517-335-9871 Web: <a href="http://www.michigan.gov/mdhhs/lab">www.michigan.gov/mdhhs/lab</a></p>																			
SUBMITTER INFORMATION																			
<div style="writing-mode: vertical-rl; transform: rotate(180deg);">SUBMITTER INFORMATION PRINTED, TYPED OR STAMPED</div> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>															<input type="checkbox"/> FP		AGENCY CODE (If Known) <div style="border: 1px solid black; width: 100%; height: 20px;"></div>		
															TELEPHONE <div style="border: 1px solid black; width: 100%; height: 20px;"></div>				
															FAX <div style="border: 1px solid black; width: 100%; height: 20px;"></div>				
															NATIONAL PROVIDER IDENTIFIER # <div style="border: 1px solid black; width: 100%; height: 20px;"></div>				
CONTACT PERSON/ORDERING PHYSICIAN/PROVIDER NAME																			
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>																			
PATIENT INFORMATION																			
NAME (LAST, FIRST, MIDDLE INITIAL) or UNIQUE IDENTIFIER																			
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>																			
SUBMITTER PATIENT # (If Applicable)										CITY									
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ZIP				GENDER				RACE											
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other											
ETHNICITY								ADAP NUMBER				BIRTH DATE (MM-DD-YYYY)							
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown								<div style="border: 1px solid black; width: 100%; height: 20px;"></div>				<div style="border: 1px solid black; width: 100%; height: 20px;"></div>							
SUBMITTER SPECIMEN #										COLLECTION DATE (MM-DD-YY)					COLLECTION TIME (MILITARY)				
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Complete  
all areas  
highlighted

on the top  
portion of  
the form



Indicate  
source in  
highlighted  
area

Check  
“Other” Box  
and write  
in:  
COVID-19

INDICATE TEST REQUESTED			
INSTRUCTIONS FOR COMPLETION: Complete reverse side of form for corresponding numbers in parentheses and in bold.			
<b>INDICATE SPECIMEN SOURCE</b> <input type="checkbox"/> AMNIOTIC FLUID <input type="checkbox"/> BRONCHIAL <input type="checkbox"/> CERVIX <input type="checkbox"/> CSF <input type="checkbox"/> GASTRIC <input checked="" type="checkbox"/> NASOPHARYNGEAL <input type="checkbox"/> ORAL MUCOSAL TRANSUDATE <input type="checkbox"/> PLASMA <input type="checkbox"/> SERUM <input type="checkbox"/> STOOL <input type="checkbox"/> SPUTUM <input type="checkbox"/> THROAT <input type="checkbox"/> URETHRA <input type="checkbox"/> URINE <input type="checkbox"/> WHOLE BLOOD <input type="checkbox"/> FOOD-Specify: <input type="checkbox"/> OTHER-Specify:	<b>SEROLOGY</b> SERUM STATUS - If Applicable <input type="checkbox"/> ACUTE <input type="checkbox"/> CONVALESCENT <input type="checkbox"/> ARBOVIRUS ENCEP PANEL (IgM) May-Oct Includes: Eastern Equine, California, St. Louis and West Nile      CSF Only <input type="checkbox"/> BRUCELLA SEROLOGY <input type="checkbox"/> FUNGAL SEROLOGY COMPLEMENT FIX <input type="checkbox"/> FUNGAL IMMUNODIFFUSION <input type="checkbox"/> FRANCISELLA SEROLOGY <input type="checkbox"/> LEGIONELLA - HA <input type="checkbox"/> LYME DISEASE - EIA (4) <input type="checkbox"/> MEASLES IgG <input type="checkbox"/> MUMPS IgG <input type="checkbox"/> RABIES AB SEROLOGY (3) <input type="checkbox"/> RUBELLA IgG <input type="checkbox"/> TETANUS TOXIN EIA <input type="checkbox"/> VARICELLA ZOSTER IgG	<b>MICROBIOLOGY</b> <input type="checkbox"/> AEROBIC ISOLATE ID (5) <input type="checkbox"/> ANTIMICROBIAL RESISTANCE CONF. (5) <input type="checkbox"/> AFB SLIDE/CULTURE-CLINICAL SPECIMEN <input type="checkbox"/> AFB IDENTIFICATION-ISOLATE ID <input type="checkbox"/> ENTERIC BACTERIAL CULTURE <input type="checkbox"/> FOODBORNE ILLNESS-Stool or Food (6) <input type="checkbox"/> FUNGAL IDENTIFICATION - ISOLATE ID <input type="checkbox"/> LEGIONELLA CULTURE <input type="checkbox"/> NEISSERIA GONORRHOEAE - ISOLATION <input type="checkbox"/> NEISSERIA - REFERRED CULTURE <input type="checkbox"/> PARASITOLOGY - BLOOD <input type="checkbox"/> PARASITOLOGY - STOOL <input type="checkbox"/> PARASITOLOGY - WOB <input type="checkbox"/> PERTUSSIS PCR <input type="checkbox"/> SALMONELLA SEROTYPING - HUMAN <input type="checkbox"/> SHIGELLA SEROTYPING <input type="checkbox"/> E. COLI SHIGA-TOXIN PRODUCER (STEC)	<b>TESTS THAT REQUIRE MDHHS APPROVAL</b> EMERGING ARBOVIRUS PANEL <input type="checkbox"/> PCR <input type="checkbox"/> SEROLOGY <input type="checkbox"/> AFB NUCLEIC ACID AMPLIFICATION <input type="checkbox"/> BACTERIAL TYPING-PFGE (6) <input type="checkbox"/> BOTULISM TOXIN <input type="checkbox"/> MUMPS - PCR <input type="checkbox"/> MEASLES IgM <input type="checkbox"/> NOROVIRUS PCR (6) <input type="checkbox"/> PERTUSSIS CULTURE <input type="checkbox"/> RUBELLA IgM (1) <input type="checkbox"/> SALMONELLA SEROTYPING NON-HUMAN <input type="checkbox"/> TOXIC SHOCK TESTING <input checked="" type="checkbox"/> OTHER COVID-19
<b>HIV TESTING</b> <input type="checkbox"/> HIV Ag/Ab - Serum (1) <input type="checkbox"/> HIV Ag/Ab-Oral Mucosal Transudate (1) <input type="checkbox"/> CD4/CD8 (EDTA whole blood) (1) <input type="checkbox"/> HIV-1 VIRAL LOAD (EDTA plasma) (1) <input type="checkbox"/> HIV-1 GENOTYPING (EDTA plasma) (1)	<b>SYPHILIS TESTING</b> <input type="checkbox"/> SYPHILIS PANEL (1) <input type="checkbox"/> SYPHILIS TP-PA (ONLY) (1) <input type="checkbox"/> SYPHILIS VDRL - CSF Only (1) <input type="checkbox"/> SYPHILIS DFA (1,2) <input type="checkbox"/> SYPHILIS IgM WESTERN BLOT* (1)	<b>VIROLOGY</b> <input type="checkbox"/> ENTEROVIRUS PCR (6) <input type="checkbox"/> RESPIRATORY PCR PANEL <input type="checkbox"/> INFLUENZA (PCR/CULTURE) (7) PATIENT STATUS (Influenza) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> VIRAL CULTURE	<b>OTHER</b> <input type="checkbox"/> AUTOCLAVE TEST STRIPS <input type="checkbox"/> LEGIONELLA - DFA <input type="checkbox"/> LYME DISEASE - DFA (Tick) <b>HEPATITIS TESTING</b> <input type="checkbox"/> HEPATITIS C ANTIBODY (1) <input type="checkbox"/> HEPATITIS B SURFACE ANTIGEN (HBsAg) (1) <input type="checkbox"/> HEPATITIS B ANTIBODY (Anti-HBsAg) (1) <input type="checkbox"/> HEPATITIS A ANTIBODY (IgM) (1)

# Packaging samples cont.

Place frozen ice pack  
inside styrofoam  
insert within the box



Place 95kPa bag with  
sample on top of  
frozen ice pack in box





# Packaging samples cont.

- Place styrofoam lid on top

- Place completed State of Michigan-Laboratory Test Requisition on top of styrofoam lid

INDICATE TEST REQUESTED			
INSTRUCTIONS FOR COMPLETION: Complete reverse side of form for corresponding numbers in parentheses and in bold.			
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<b>HIV TESTING</b> <input type="checkbox"/> HIV Ag/Ab - Serum (1) <input type="checkbox"/> HIV Ag/Ab-Oral Mucosal Transudate (1) <input type="checkbox"/> CD4/CD8 (EDTA whole blood) (1) <input type="checkbox"/> HIV-1 VIRAL LOAD (EDTA plasma) (1) <input type="checkbox"/> HIV-1 GENOTYPING (EDTA plasma) (1)	<b>SYPHILIS TESTING</b> <input type="checkbox"/> SYPHILIS PANEL (1) <input type="checkbox"/> SYPHILIS TP-PA (ONLY) (1) <input type="checkbox"/> SYPHILIS VDRL - CSF Only (1) <input type="checkbox"/> SYPHILIS DFA (1,2) <input type="checkbox"/> SYPHILIS IgM WESTERN BLOT* (1)	<b>VIROLOGY</b> <input type="checkbox"/> ENTEROVIRUS PCR (6) <input type="checkbox"/> RESPIRATORY PCR PANEL <input type="checkbox"/> INFLUENZA (PCR/CULTURE) (7) PATIENT STATUS (Influenza) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> VIRAL CULTURE	<b>OTHER</b> <input type="checkbox"/> AUTOCLAVE TEST STRIPS <input type="checkbox"/> LEGIONELLA - DFA <input type="checkbox"/> LYME DISEASE - DFA (Tick) <b>HEPATITIS TESTING</b> <input type="checkbox"/> HEPATITIS C ANTIBODY (1) <input type="checkbox"/> HEPATITIS B SURFACE ANTIGEN (HBsAg) (1) <input type="checkbox"/> HEPATITIS B ANTIBODY (Anti-HBsAg) (1) <input type="checkbox"/> HEPATITIS A ANTIBODY (IgM) (1)

DCH - 0583 (Rev. 01-19)

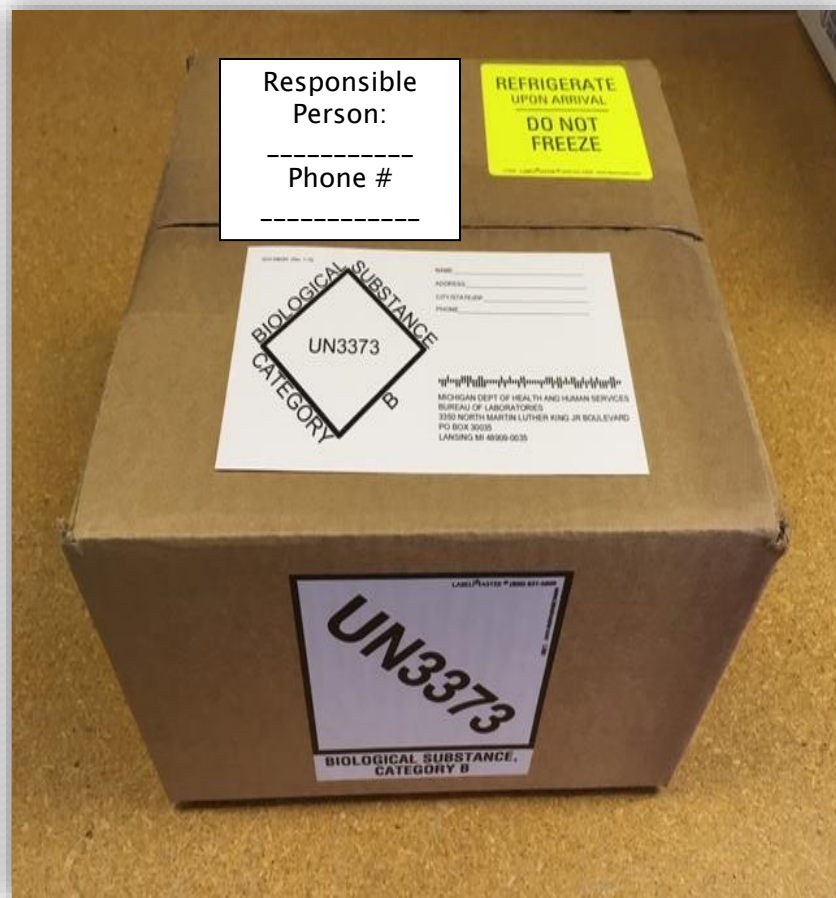
# Shipping Options

- Courier transport to BOL
  - Use Address label in kit # 51 with address:  
3350 North Martin Luther King Jr. Blvd., Lansing
- UPS (if courier is unavailable) Monday-Thursday only
  - Use UPS label included in kit # 51 with address:  
927 Terminal Rd (our warehouse address)
- UPS (if courier is unavailable) Friday only
  - Call the lab to have Friday overnight UPS label faxed to you. Contact (517) 335-8059
- **Weekend Delivery:** Use your facility courier or refrigerate sample for Monday delivery
- **For Urgent Requests contact: (517) 335-9030**



# Shipping with Courier-Outer Box

- Close box and tape with packing tape.
- Place address label on top of sealed box
  - Fill in your name and facility address on label
- Place UN3373 Category B label on side of outer box
- Write full name and phone number with area code of Responsible Person from your facility on Top of box
- Place “refrigerate” yellow label on box



# UPS Shipping-Monday-Friday ONLY

- Close box and tape with packing tape.
- Place UPS label on top of sealed box
- Place UN3373 Category B label on side of outer box
- Write full name and phone number with area code of Responsible Person from your facility on top of box
- Place “refrigerate” yellow label on box





## For Testing Questions Contact:

<b>Dr. Diana Riner</b> Virology Section Manager	(517) 335-8099	<a href="mailto:rinerd@michigan.gov">rinerd@michigan.gov</a>
<b>Bruce Robeson</b> Viral Isolation & Molecular Testing Unit Manager	(517) 335-8098	<a href="mailto:robesonb@michigan.gov">robesonb@michigan.gov</a>
<b>Kris Smith</b> Unit Manager/Bacterial & Viral Serology	(517) 335-8100	<a href="mailto:SmithK8@michigan.gov">SmithK8@michigan.gov</a>

## For Packaging and Shipping Questions Contact:

<b>Shannon Sharp</b> Bioterrorism Training Coordinator	Office: (517) 335-9653 cell (517) 331-7356	<a href="mailto:SharpS1@michigan.gov">SharpS1@michigan.gov</a>
<b>Matt Bashore</b> Supervisor DASH Unit	Office:(517) 335-8059 Cell: (517) 648-9804	<a href="mailto:bashorem@michigan.gov">bashorem@michigan.gov</a>